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ABSTRACT

This paper examines the health status of Asian Americans. In introductory sections, the paper looks at: patterns of Asian immigration, myths surrounding Asian Americans as a "model minority," such as the false notion that Asian Americans as a group are always academic and economic achievers despite their minority status; institutional, cultural, and individual racism; and similarities across Asian American ethnic groups. Major sections of the paper focus on: (1) the health status of Asian Americans, including violence, substance abuse, mental health, AIDS, sexually transmitted diseases, teenage pregnancy, and nutritional status; (2) barriers that keep Asian Americans from seeking health service; and (3) the importance of developing cultural competence in areas such as health beliefs, sexuality, communication style, and racism. Finally, implications for health service providers are examined and elements delineated for: a comprehensive health promotion system; sexual health education programs; Alcohol, Tobacco, and Other Drugs (ATOD) prevention programs; mental health interventions; violence reeducation programs; and nutrition education programs. (Contains 39 references.) (ND)

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Health Education: Addressing the Asian-American Student

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Introduction

Although they currently comprise only 3% of the population, Asian-Americans and Pacific Islanders (hereafter collectively referred to as Asian-Americans) are the fastest growing minority group in the U.S. In 1965, there were only 1 million Asian-Americans; today, they number 8.8 million. (U.S. Census Bureau, 1993) Asians are expected to account for about 15% of the nation's total population growth between 1990 and 2000, and for 18% between 2000 and 2010. During the last eight years, more than 800,000 Southeast Asians have settled in the U.S.; the largest percentage of these immigrants reside in California, Hawaii, New York, Illinois and Texas.

Figures from 1994 indicate that 60% of Asian-Americans are foreign-born, (Garza, 1994) and 69% speak a language other than English at home. (U.S. Census Bureau, 1980) A heterogenous population, Asian-Americans are characterized by a rich diversity of over 43 ethnic groups, speak over 100 languages and dialects, and practice a wide array of cultural traditions. Note too, that Asian-Americans of first generation descent differ greatly from third or fourth generation Asian-Americans.

Waves of Asian Immigration

1800's	Chinese were brought to the West Coast to build the railroads as indentured labor.
1940-1980	"Cream of the crop" scientists, researchers, professors, etc. and other high socioeconomic status individuals legally entered the U.S. to further their education, attain political freedom, and seek better employment opportunities. A self-selected group, these immigrants were heartily welcomed by corporate America.
1980-present	Southeast Asians immigrate illegally and therefore are disenfranchised, both politically and economically. They form the ranks of the invisibly oppressed, facing high unemployment, poverty, gangs, homicide, violence, substance abuse and AIDS.

The "Model Minority" Myth

This is a myth that has been perpetrated widely by the media. It refers to the false notion that Asian-Americans as a group are always academic and economic achievers despite their minority status. It is true that a higher percentage of Asians have a college education as compared to non-Asians, and that the median income for Asian-American families is slightly higher than the national average. This is due partly to Asians' strong work ethic and their strong regard for education as the key to upward mobility. They engage in longer work weeks, and do not hesitate to make greater educational investments.

Asians are also disproportionately represented in the fields of engineering, math, physical sciences and medical research. Some say this is because of their discomfort in social situations. Consistent with the "model minority" myth is the stereotypical perception that Asians are successful, compliant, quiet, and appropriately subservient.

However, this profile obscures serious problems in such Asian-American communities as "Chinatown." These problems include poverty, substance abuse, mental illness, gangs and domestic violence. Figures about income are often skewed because Asians tend to live in larger, extended families, pooling all of their economic resources. Also, many recent Asian immigrants and refugees live below the poverty line; 13% of Asian-Americans are poor, versus 12% nationally.

The "model minority" myth also portrays Asians as having excellent health. However, there is inadequate data on the health status of Asian-Americans, and few studies distinguish between recent immigrant arrivals and established, enfranchised groups. Unfortunately, many Asian-Americans buy into this "model minority" myth themselves. They believe erroneously that members of their community don't engage in high-risk sexual behavior or use intravenous drugs.

Institutional Racism

Structurally, Asians are the invisible minority. They become lost in the "black and white" dichotomy of our society, caught in the "No Man's Land" between Caucasians and African-Americans. They are accepted by Caucasians as long as they remain within the boundaries of deference proscribed by the "model minority" myth. On the other hand, a "glass ceiling" is placed on how far Asians can advance; Caucasians oftentimes feel threatened and "scapegoat" Asians for their own economic plight.

Asians are held up to African-Americans and Hispanics by Caucasians as examples of minority groups who can succeed, therefore implying that other groups are too lazy, too stupid, etc. (Kim, 1993) This manipulation breeds separatism and tension between minority groups. In comparing Asians with other minorities, the government and business can downplay obstacles which hinder minority groups. As a result, however, Asians become targets for resentment.

The Japanese were interred in concentration camps during World War II. Our federal government has only recently recognized the serious injustice and violation of civil rights this act constituted.

Racism against Asian-Americans has been negatively impacted by U.S. foreign policy. Conversely, it has led to stricter immigration laws against Asians. A prime example is the ill-fated voyage of the *Golden Venture*, which grounded in New York City in 1993; very few Americans sympathized with the pitiful plight of those Chinese immigrants.

Cultural Racism

Asian-Americans are confronted with stereotypes, judgements based on myths, name-calling, oppression, prejudice, ridicule, mistreatment, ostracization and violence as a result of their race. Their physical differences cannot be hidden; their culture is viewed as strange. Some of this prejudice surfaced during the Los Angeles riots during Summer 1992. Media portrayals of Asians -- particularly of the men -- are seldom favorable. There is also a perception that Asians in business are sneaky, conniving and untrustworthy -- always looking for ways to "cheat" the customer; in fact, a 1994 poll by the National Conference of Christians and Jews found that four in 10 blacks and hispanics, and 27% of white concur with the stereotypes that Asian-Americans are "unscrupulous, crafty and devious in business." (Goldberg, 1994)

GI's stationed on U.S. military bases in Asian countries fostered an economy of prostitution among Asian women. Asian women were raped and violated with impunity during the Korean and Vietnam Wars. They are regarded as passive, exotic creatures to be dominated -- this is part of their appeal as "mail-order" brides for American men. There are an estimated 250,000 Asian "military brides." However, until very recently interracial couples drew disapproval and sometimes hate. The products of these marriages, Amerasian children, have been abandoned or brought back to the U.S. to isolated bases, rejected by the mainstream culture. These are the legacies brought back by veterans.

Individual Racism

Across the U.S., anti-Asian violence has noticeably increased in recent years. In 1982 a Chinese-American man, Vincent Chin, was beaten to death by two autoworkers angry at the Japanese for supposedly "causing" the recession in Detroit's auto industry. The perpetrators were convicted of "manslaughter." As punishment, they received three years of probation and were required to pay $3,750 in fines. That is how little Asian lives are worth.

Many Asian groups were targeted in December 1991 around the 50th anniversary of the bombing of Pearl Harbor. Numerous anti-Japanese incidents occurred on the West Coast.

Similarities Across Asian-American Ethnic Groups

Salience of Family and Community. The family and community are vital parts of each individual's lifestyle, to the point that the needs of the family almost always supersede those of the individual. Everyone works for the good of the family, no matter the cost. Independence and autonomy are rarely stressed. Elders are always to be revered. Youth are expected to be obedient and filial; they must excel in school and fulfill family duties, such as carrying on the family name with sons, or taking over the family business.

Preservation of Family Honor. Help-seeking behavior is discouraged. Problems and personal issues are not to be discussed with members outside the community; they should instead be solved within the immediate and extended family. Individuals are expected to preserve family honor and "save face." Displaying feelings makes you vulnerable. It is preferable to hide personal problems than to bring shame to the entire family. Divorce is frowned upon.

Harmony and Order. Conflict is intolerable as it upsets the family balance. As such, indirect and non-verbal communication is preferable. Direct confrontation is avoided if possible, and self-restraint in public is admired. In order to preserve harmony, women in particular are taught to silently accept suffering and mistreatment, rather than change an intolerable situation. Perseverance is a valued feminine virtue, building character.

Female Subservience. Fathers, husbands, brothers and eldest sons have authority over a woman throughout various stages of her life; she is financially and socially dependent on them. A man's opinion and desires should always take precedence over a woman's. Males are valued because only they can carry on the family name and ancestral lineage. Asian women define their identity through their relationships. She is considered property of her husband, bought and paid for by the man's family. As such, she should be submissive, uncomplaining and devoted.

Sexual Taboos. Women are expected to be chaste and pure; men can openly visit prostitutes and have several wives in many Asian cultures. However, sexual discussions are virtually taboo. There are many inhibitions about discussing sex and sexuality openly or publicly. In addition, homosexuality is not accepted in traditional culture.

Similarities Across Asian-American Ethnic Groups (continued)

Violence. Corporal punishment and physical discipline of children are common and supported by the culture. Similarly, physical abuse of wives is tolerated more in Asian cultures. Marital rape is not recognized, since a wife is not allowed to refuse her husband sex -- it is her duty.

Healing and Health. Any discussion of illness or death is regarded as a self-fulfilling prophecy. Physical and psychological distress are believed to be the result of spirit possession or ancestral intervention. Asians may therefore adhere to different healing and treatment modalities. More than Western cultures do, Asians believe strongly in the mind-body connection.

Fatalism. There is a strong cultural and religious sense that Fate governs the future. Many Asians are resigned to the notion that ancestral spirits can determine behavior and outcomes. It is considered futile and even bad luck to try to change one's destiny. Instead, one is expected to willingly accept one's lot in life, good or bad.

Health Status of Asian-Americans

Health experts have observed that with each succeeding generation, the health status of Asian-Americans changes. Much like African-Americans and Hispanics in the U.S., first and second generation Asians do not fare as well as whites on many health indicators. For example, recent Asian immigrants experience high rates of infectious diseases such as tuberculosis and hepatitis B. However, because of their tremendous ability to assimilate, later generations possess a health profile which increasingly resembles that of the mainstream population, characterized by such chronic conditions as substance abuse, obesity, heart disease, cancer, etc.

Health status is further complicated by the fact that Asian-Americans may be underinsured. A Harris Poll (1994) found that nationally, 41% of Koreans lacked health insurance, compared to only 31% among all other minorities and 14% among whites.

Violence. Violence against Asian-American women is a subset that requires special attention among the college-age population. The F.B.I. estimates that one in four women will be raped in her lifetime. Although sufficient research has yet to be conducted in this area, it is highly likely that Asian-American women, like African-American and Hispanic women, are sexually assaulted at higher rates than white women. One recent, unpublished study conducted at Stanford University by Alejandro Martinez indicated that Asian women tend to be targeted as victims by white male students with privileged status, such as athletes and fraternity leaders.

Cultural traditions normalize women's victimization, as well as their secondary, subservient status to men in Asian communities; she must defer, be obedient and display passiveness. Women are taught to avoid direct confrontation and thus usually submit to aggression instead. Because many Asian women are unable to label or acknowledge their battery or sexual assaults as such, they become "hidden victims" of violence. She is unlikely to report

Health Status of Asian-Americans (continued)

domestic violence or rape in order to preserve the family honor. Similarly, Asian men are less likely than non-Asian males to perceive their aggression as wrong. (Mills & Granoff, 1992)

Pornography of Asian women is among the most violent. Furthermore, the business of prostitution and wife-selling are thriving rampantly in the Asian underworld, both here in the U.S. and in Asia. In fact, women in Thailand are praised for their efforts in maintaining the economy of the country; they are regarded as heroines when they return to their villages, bringing back with them wealth.

In addition to the verbal harassment, hate crimes and other physical assaults that Asian-American youth face as a result of racism and prejudice, Asian-American youth also experience violence within the community. A growing number of Asian gangs who traffic in drugs and weapons or run prostitution rings are developing in large metropolitan centers such as Houston, San Francisco, Los Angeles, and New York, as well as in some of the smaller cities. These gangs face the same risks of violent death that Hispanic or African-American gangs confront.

Substance Abuse: Alcohol, Tobacco, and Other Drugs. ATOD use and abuse among Asian-Americans seems to differ by measures of sex, ethnic background, age, place of birth, and personal attitudes. For example, there are substantial differences in alcohol consumption across Asian groups. However, the research on these differences is contradictory and inconclusive. Some studies report that among nationals, Chinese alcohol use and dependency remain low, while Koreans have fairly high rates of alcohol consumption and abuse in their homelands. Some have found this difference to be reflected among Chinese-Americans and Korean-Americans. Others have found that Korean-Americans are most likely to be abstainers compared to other Asian-American groups. One study found that Japanese, Korean, and Filipino men actually share roughly the same percentage of heavy drinkers -- 28%. What is clear from these statistics is that not enough is known about the drinking behaviors of Asian-Americans, given the diversity of ethnic groups represented. Self-reports may also underestimate consumption patterns.

In general, though, Asian-Americans seem to consume alcohol and exhibit alcohol dependency at lower rates than the general population. They experience lower rates of mortality than other ethnic groups for most alcohol-related causes of death, e.g. cirrhosis, motor vehicle crashes. However, because many Asians possess less of the enzyme *alcohol dehydrogenase* (ALDH), which metabolizes alcohol, these individuals are more susceptible to alcohol's intoxicating effects -- commonly referred to as the "flushing response." This facial flushing may be accompanied by headaches, dizziness, tachycardia (excessively rapid heart beat), hypotension, nausea, vomiting, itching, and other symptoms.

Although some studies have found that flushing appears to deter alcohol use, Asians with this trait may nevertheless consume alcohol. In fact, several researchers have recently challenged the previously-held belief that Asian-Americans are categorical abstainers and have few, if any, alcohol-related problems because of the unpleasant physiological effects of alcohol. An alternative view suggests that ALDH-deficient Asians have more intense, although not necessarily unpleasant and negative, reactions to alcohol. Some studies show that ATOD use

Health Status of Asian-Americans (continued)

among Asian-Americans may actually be on the rise, particularly as they become more assimilated into mainstream culture.

With regard to tobacco use, Southeast Asian-American men have one of the highest rates of cigarette smoking compared to other ethnic groups. Their lung cancer rate is correspondingly 18% higher than whites, and liver cancer is 12 times higher among Southeast Asians than among whites. Chinese-Americans have also been found to use Quaaludes at higher rates than other ethnic groups.

Asian-Americans, particularly adolescents, are at greater risk for substance abuse based on measures of depression, poor relationship with their parents, sensation seeking, low religiosity, and especially low self-esteem. Other studies have found that Japanese men are particularly influenced by their friends who drink, while Koreans are more strongly influenced by the drinking habits of their parents. One study found that among Chinese men, those who were more educated were more likely to drink. Finally, substance abuse also appears to be strongly correlated with stress among Asian-Americans.

Mental Health. Stress among Asian-Americans is pervasive, often hidden, and has been associated with a number of factors. Straddling cultural extremes for all generations takes a tremendous emotional toll. There are also varying but significant experiences of trauma among refugee populations, for example among Southeast Asian populations. Often, when succeeding generations become more acculturated than their parents, conflicts between generations arise. Asian youths are under greater and unreasonable pressure to succeed academically and professionally. Stress often becomes the price of survival. (McGrath, Delaney & Zagorin, 1983) In Asian cultures, individual control over life choices is subjugated to the survival and harmony of the family unit. Asian-Americans also self-report more feelings of discomfort and inhibition in difficult social situations when compared to their white counterparts. (Sue, et.al., 1983)

Asians also demonstrate a very low physical self-concept, given the predominant and unattainable standards of beauty in the mainstream culture. Studies have found that Asian-American females are more dissatisfied with their bodies than their white counterparts. Eating disorders as one manifestation of poor self-concept has been the subject of some study, finding that eating problems are significantly more prevalent among Asian women than white women. In another study of college-age women, Lucero, et.al. (1992) initially found that there was no significant difference in symptomatology of eating problems between Asian and white women. However, while 60% of Asian women and 57% of Caucasian women were found to have symptoms of disordered eating, Caucasian women were 5.5 times more likely to self-report an eating problem. Under-reporting, particularly among Asian-Americans, conceivably contributes to an underestimation of health problems in this population.

Asian-American adolescents who are confronted with the difficult task of formulating an operational and cross-cultural self-identity often fall prey to a sense of lost identity, negative self-image, and a "second-class mentality." (Chun, 1980) The U.S. Department of Health and Human Services reports higher rates of proportional mortality and years of potential life lost due

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Health Status of Asian-Americans (continued)

to suicide among Asian-American youth between the ages of 15 and 24 as compared to the national average, particularly among Chinese-Americans and Japanese-Americans. Furthermore, suicide rates among Asian-Americans are on a drastic rise. Between 1970 and 1980, suicide rates among Chinese-Americans increased 114% (2.98 per 100,000 to 6.39 per 100,000), compared to an increase of 51% among white adolescents. Proportional mortality increased 200% during that time for Chinese-Americans (5.6 to 16.8) versus a 53% increase among white adolescents (7.8 to 12).

While males have significantly higher suicide rates than females across ethnic groups (by a factor of 3.3), Chinese-American women commit suicide at rates comparable to Chinese-American men (8.0 per 100,000 versus 7.9 per 100,000). Chinese- and Japanese-American women generally commit suicide in greater proportion than white women, and among Japanese-Americans, there is a minor peak in suicide rates among adolescents and young adults -- particularly among young men. Finally, for every successful youth suicide, researchers predict that there are as many as 200 attempts.

Help-seeking behavior of Asian-Americans is a critical issue in the promotion of their mental health. Solberg, et.al. (1994) found that Asian-American college students who are less identified with the majority culture are more likely to seek help from community elders, religious leaders, student organizations (such as the Asian-American Students Association), and church groups -- all of which may be regarded as nontraditional sources of help by many service providers.

Given different cultural acceptance and attitudes about mental illness, many Asian-Americans with psychological issues and who seek medical attention may only identify somatic rather than emotional disturbances. (Lippincott & Mierzwa, 1995) These somatic complaints may, however, suggest an underlying psychological problem such as depression, anxiety disorder, etc. It is important for practitioners to pursue this possibility. Given the likelihood of drastic measures for coping with psychological stress, it is critical that mental health programs recognize the needs of the Asian-American population.

AIDS. The total number of AIDS cases among Asian-Americans reported to the Centers for Disease Control increased an alarming 317% from 488 to 2,036 cases between January 1989 and June 1993. The AIDS case rate for Asians was 4.8 per 100,000 as of June 1993. (CDC) Seventy-five percent of all adult cases have been attributed to male homosexual/bisexual contact and 4% to IV drug use. Fourteen percent of AIDS cases occur in persons over age 50 -- a higher rate than among whites, blacks, Hispanics or Native Americans. While 1% percent of Asian-American males contracted HIV through heterosexual contact, 35% of females did, which is higher than the rate found among white, black, Hispanic or Native American women.

No national statistics are available by Asian ethnic subgroups, and widespread underreporting is a problem. Immigrants may leave the country. Many Asians do not seek medical care because of strict naturalization laws and possible deportation. Also, most Asians hide AIDS until the later stages in order not to shame the family or anger ancestral spirits.

Health Status of Asian-Americans (continued)

Furthermore, statistics for Asian-Americans with AIDS were not kept as a separate sub-group until 1989. Previous to this, individuals of mixed heritage were lumped under another group. An estimated 50% of Asians with AIDS are first generation, which is problematic given the high rates of tuberculosis which infect this population.

Resources for prevention, research, training and education for Asian communities are scarce. What little research there is in this area demonstrates that knowledge among Asian-American adolescents is less than their non-Asian counterparts. For Asian youth, there is minimal personalization of the HIV threat; many don't know people with HIV. Most alarmingly, many falsely believe that if members of the Asian community adhere to traditional cultural norms and don't have sex or marry outside of the community, they won't be at risk. AIDS is regarded as the disease of "white devils" only -- supporting the dangerous myth that Asians are immune.

Sexually Transmitted Diseases. An estimated 78% of girls and 86% of boys have engaged in sexual intercourse by age 20. While levels of sexual activity may be less among Asian-American youth given the strict cultural sanctions against premarital sex, the sexual practices of Asian-American college students tends to resemble those of their non-Asian peers. (Yep, 1993)

By age 21, one in four young people has received treatment for an STD. While no research has focused specifically on incidence rates among this population, STD transmission is certainly an area of concern among sexually active Asian-American students. Current statistics are prone to underreporting; Asian-American youth may be hesitant to seek medical care and seldom lack sufficient knowledge about symptoms or how to perform a genital self-exam. As with non-Asian adolescents, prevention of STD is consistent with HIV risk-reduction.

Teenage Pregnancy. One in 10 young women aged 19 and younger become pregnant each year. Teenagers account for about one third of all unintended pregnancies, with 75% of these pregnancies occurring among teens who are not using contraception. Minority adolescent females experience greater numbers of out-of-wedlock births than do their white counterparts. Asian-American women in particular may lack the skills or knowledge to effectively use contraception. In addition, guilt and anxiety about sexual activity may preclude pregnancy prevention.

Nutritional Status. Carbohydrate-containing foods such as rice and rice noodles, rather than meat, are the major source of caloric intake in the traditional diet of Asian-American ethnic groups. In general, Asian diets, as compared to typical U.S. diets, are richer in vegetables, fruits, fish and shellfish, but lower in meat and dairy products.

The short cooking time of many traditional Asian foods is favorable to nutrient retention. Complex carbohydrates and sodium are high in Asian diets, while total fat, saturated fat, calcium, iron, and some vitamins (such as B) are relatively low. Inadequate calcium intake among Asians is associated with limited use of dairy foods, either due to lactose intolerance or

Health Status of Asian-Americans (continued)

culturally-determined food avoidances. "Status foods" -- foods in the traditional culture which are only accessible to Asians of higher socioeconomic status because of their availability or price traditional -- include both nutritious foods such as fruit, vegetables and ice cream, and low-nutrient foods such as soft drinks and candy.

Many of the nutritional risks associated with Asian-Americans are the result of adaptation to American dietary patterns. Dietary alterations result in greater relative weight and higher coronary heart disease mortality; nutritionally-related diseases of higher prevalence include hypertension and strokes. Growth stunting (i.e., low height for age) is commonly found among recent migrated Southeast Asian refugees. On a favorable note, however, because many Asian-American foods (e.g., pickled vegetables, salted eggs, dried fish) and seasonings are high in sodium, dietary acculturation among Asian-Americans may even result in lower hypertension risk.

Barriers to Service Utilization

Asian-Americans are less likely than other groups to seek health information, medical treatment, or mental health services. There are several reasons for this:

Institutional

- Shortage of culturally-sensitive and culturally-relevant services which provide primary, secondary and tertiary care
- Lack of bilingual health educators and health care providers
- Inadequacy of Asian languages for discussing sexual and other health issues -- many concepts/behaviors do not translate easily
- Lack of culturally-appropriate, bilingual educational materials, both written and audio (high illiteracy rates exist among Asians)
- Lack of proper financing for Asian-American health problems
- Racism among mainstream agencies and funding organizations
- Paucity of research and needs assessment among Asian communities
- Failure of health professionals to identify and recognize health problems in the Asian-American community
- Lack of health care insurance

Cultural

- The Asian culture dictates that individuals don't venture outside the immediate or extended family to ask for assistance, otherwise that person "loses face" (males especially take pride in not seeking help)
- Trust and confidentiality issues -- in ensuring the privacy and sovereignty of the Asian family, members are not supposed to discuss feelings or personal issues with outsiders

Barriers to Service Utilization (continued)

- Taboos associated with sexuality and AIDS, homophobia, and denial of drug abuse within the Asian-American communities
- Notion of preventive health care measures is unfamiliar to Asians
- Conflict between Western medical practices and Asian-American healing modalities

Developing Cultural Competence

Health behaviors are not simply a personal decision; they always occur within a context of social and environmental factors. Therefore, understanding attitudes, values and cultural beliefs about a range of health-related issues -- including sexuality, substance abuse, healing, etc. -- is critical to providing effective prevention education. Prevention efforts then need to be placed in a cultural context.

A Youth Leader's Guide to Building Cultural Competence, developed by Advocates for Youth, (1994) proposes a four-step model of building **cultural competence** for working effectively and respectfully with youth audiences from a variety of backgrounds. The four steps are:

(1) learning about culture and important cultural components;
(2) learning about your own culture through a process of self-assessment which includes examining your culture's assumptions and values and your perspectives on them;
(3) learning about the individual people who will comprise your audiences; and
(4) learning as much as possible about important aspects of their cultural backgrounds with a focus on sexuality-related issues.

Note: The following information was excerpted from pages 5-6 and 11-21 in the Advocates for Youth manual.

Cultural competence moves beyond the concept of "cultural awareness" (the knowledge about a particular group primarily gained through reading or studies) and "cultural sensitivity" (knowledge as well as some level of experience with a group other than one's own). Rather, achieving cultural competence is a long-term developmental process; culturally competent individuals have a mixture of beliefs, attitudes, knowledge and skills which facilitate establishing trust and communicating with others.

Cultural competence includes: (1) the personal recognition and acceptance that all types of cultures have a profound influence on our lives; (2) the personal awareness that oppression is pervasive in the U.S., is part of American history, and -- as much as we want to deny it -- colors relationships; (3) learning to respect what we may not always understand; (4) having the humility to accept we don't know everything about other cultures nor ever will, and therefore that we need to assess what it is we need to know about the specific groups with whom we are working; and (5) a willingness to pursue information in all ways available to us.

Developing Cultural Competence (continued)

Beliefs and Attitudes. The culturally competent individual is:

- aware of and sensitive to his/her own cultural heritage, as well as respects and values different heritages;
- aware of his/her own values and biases and how they may affect perception of other cultures;
- comfortable with differences which exist between his/her culture and other culture's values and beliefs; and
- sensitive to circumstances (personal biases, ethnic identity, political influence, etc.) which may require seeking assistance from a member of a different culture when interacting with another member of that culture.

Knowledge. The culturally competent individual must:

- have a good understanding of the power structure in society and how non-dominant groups are treated;
- acquire specific knowledge and information about the particular group(s) s/he is working with; and
- be aware of institutional barriers which prevent members of disadvantaged groups from using organizational and societal resources.

Skills. The culturally competent individual can:

- generate a wide variety of verbal and nonverbal (body language) responses when dealing with difference;
- send and receive both verbal and nonverbal messages accurately and appropriately; and
- exercise intervention appropriately and advocate on behalf of people from different cultures. (Atkinson, Morten & Wing, 1993)

Culture is defined as the body of learned beliefs, traditions, principles and guides for behavior that are commonly shared among members of a particular group. Culture serves as a road map for both perceiving and interacting with the world. (Locke, 1992) Culture is comprised of several important components.

1. Language and Communication Style. This component refers to a wide variety of verbal and nonverbal patterns and behaviors, including social customs about who speaks to whom -- both how and when.

2. Health Beliefs. Health beliefs cover a range of assumptions about the causes of disease and how to prevent it, as well as the proper remedies for illness and who to turn to for medical care when one is sick.

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Developing Cultural Competence (continued)

3. Family Relationships. The family is the primary unit of society. In it, children are socialized into human society and into a culture's particular beliefs, attitudes, values and behaviors. The topic of family relationships include family structure, roles, dynamics and expectations.

4. Sexuality. Sexuality involves more than genital sexual activity. It includes five major areas: *sensuality*, *sexual intimacy*, *sexual identity*, *reproduction/sexual health*, and *sexualization*.

a. Sensuality is what enables people to feel good about how their bodies look and feel. It allows them to enjoy the pleasure their bodies can give to them and others. The need to be touched by others in loving ways, the feeling of physical attraction for another person, body image, and fantasy are all part of sensuality.

b. Sexual intimacy is the ability and the need to be emotionally close with another and to have that closeness returned. While sensuality refers more to physical aspects of our relationships, sexual intimacy focuses on emotional needs.

c. Sexual identity refers to people's understanding of who they are sexually, including

i. *gender identity* (their sense of being male or female);
ii. their *gender role* (what men and what women are supposed to do); and
iii. their *sexual orientation* (which sex or sexes they have primary affectional and sexual attraction to).

d. Reproduction and sexual health is the most familiar aspect of sexuality. It includes all the behaviors and attitudes having to do with having healthy sexual relationships and having the ability to bear children.

e. Sexualization is using sex to influence, manipulate or control other people. Termed the "shadow" side of sexuality, sexualization spans behaviors that range from mutually enjoyable to harmlessly manipulative to violent and illegal. It includes such behaviors as flirting, seduction, withholding sex, sexual harassment, sexual abuse, incest and rape.

5. Gender Roles. Gender roles refer to what is considered appropriate and acceptable behavior for men and women. It incorporates certain deeply-held beliefs about which behaviors are feminine and which are masculine.

6. Religion. Religion refers to a specific set of beliefs and practices regarding the spiritual realm beyond the visible world, including belief in the existence of a single being, or

Developing Cultural Competence (continued)

group of beings, who created and govern the world. Ritual, prayer and other spiritual exercises are commonly part of religious practice. Religious beliefs often provide guidance for behavior and explanations for the human condition. Finally, many -- if not all -- religions establish sexual norms.

The following six components (7-12) of culture are linked to the impact of American society on racial and ethnic groups.

7. Level of Acculturation. Acculturation is a process which occurs when two separate cultural groups come in contact with each other, and change occurs in one or both groups. Individuals within any given cultural group can be anywhere along the following continuum. Members of racial/ethnic groups can be:

a. *Acculturated* -- having given up most of the cultural traits of the culture of origin and assumed the traits of the dominant culture.
b. *Bicultural* -- able to function effectively in the dominant culture while holding on to some traits of their own culture.
c. *Traditional* -- holding on to a majority of the traits from the culture of origin while adopting only a few traits of the dominant culture.
d. *Marginal* -- having little real contact with traits of either culture. (Locke, 1992)

8. Immigration Status. Immigration status refers to whether or not an individual is classified as a *refugee*, an *immigrant*, or an *undocumented* ("illegal"). How one is labeled by the U.S. government has important implications for the kinds of services one can expect and rights one has in this country.

9. Political Power. Political power can be defined as a group's level of formal involvement in local, state and national governments, as well as in informal advocacy organizations. Those with political power are able to influence public policy decisions, often to the benefit of the groups interests. Those groups who are left out of the political process have no guarantee that they will be well-served by the process.

> **Racism** involves both prejudice against people of color and the political, social, and economic power to reinforce that prejudice. Racism always exists at individual, cultural, and institutional levels, and it can be both conscious and unconscious, both subtle and overt. (Reynolds & Pope, 1994)

10. Racism. Racism is the addition of some form of power to racial prejudice. *Prejudice* means unreasonable feelings, opinions or attitudes, especially of a hostile nature, directed against any group. Anybody can be prejudiced and everyone is. However, only those individuals or groups who are prejudiced against a racial group and have the power to act on

Developing Cultural Competence (continued)

those prejudices can be correctly labeled racist. That power is often *institutional*, meaning that racial inequalities are set in policy. The impact of racism is devastating and far-reaching.

11. Poverty and Economic Concerns. Poverty and economic concerns are tied to racism in the U.S. Often, race and socioeconomic class are confused. There is poverty in all cultural groups, and no one cultural group has only poor people in it. Therefore, questions about poverty and economic concerns such as who is employed, what kinds of jobs do they have, and how much do they get paid should be focused on a specific group of individuals, not about an entire racial/ethnic group.

12. History of Oppression. The history of the U.S. includes many chapters in which government policies harmful to racial and ethnic groups were in force. Knowing this history is important, as the legacy of these laws and policies linger today.

Implications for Health Service Providers

A comprehensive health promotion system to address Asian-American health must:

- Explore the role of racism in the provision of Asian-American health services
- Strive to foster cultural competency on the part of all service providers
- Never make assumptions about an individual student based on their ethnic appearance
- Normalize seeking of information and care
- Remove barriers to service utilization
- Increase accessibility to services
- Provide culturally-sensitive services and educational materials
- Have knowledge of attitudes, beliefs and values of Asian-Americans
- Know what might be perceived as offensive or patronizing behaviors
- Address language barriers
- Display more willingness to incorporate "traditional" or alternative healing modalities
- Encourage additional research specific to the areas of Asian-American health, as well as recognize the effect of underreporting in compiling a complete picture of Asian-Americans' health status

A multicultural campus environment is a community in which significant time, attention, and resources, both human and monetary, are dedicated to creating openness to all cultures and peoples and to eradicating social injustice. (Reynolds & Pope, 1994)

Implications for Health Service Providers (continued)

Sexual health education programs for Asian-American students should attempt to:

- Organize the community and provide role-models, as well as conduct peer leadership training
- Discuss racism, discrimination and how being different impacts sexual health issues
- Discuss and explore gender roles, sex roles, and self-image
- Clarify values relative to sexuality in general, sexual orientation, and relationships (intra- and interracial)
- Build skills in healthy sexual decision-making, safer sex negotiation, and sexual communication
- Build assertiveness skills, especially among women
- Examine the concepts of self-efficacy, self-determination and free will
- Examine the role of family upbringing, as well as the importance of family structure and community cohesion
- Discuss the impact of religion on sexual choices
- Raise awareness about substance abuse and its connection to sexual health
- Identify health resources available on campus and in the community

ATOD prevention programs for Asian-American students should attempt to:

- Clarify individual values about alcohol and other drugs
- Clarify the impact of the "flushing response," if any, on personal alcohol use
- Examine the role of the family, parents, and peers on ATOD use, attitudes, etc.
- Explore issues of self-esteem
- Provide alternative avenues of support to individuals coping with acculturation
- Encourage discussions about stress and strategies for coping with stress
- Work collaboratively with mental health programs

Mental health interventions for Asian-American students should attempt to:

- Normalize help-seeking behavior
- Reduce the stigma associated with seeking professional help outside the family
- Reduce feelings of betrayal that might be associated with discussing personal matters
- Strengthen psychological hardiness
- Encourage discussions about physical self-concept
- Encourage clients to talk about stressors, e.g. cultural, academic, social, etc.
- Assist clients in recognizing, identifying, and vocalizing emotional disturbances
- Provide role models who are comfortable talking about personal and family problems
- Provide accurate diagnosis in the absence of self-reported psychological symptoms
- Provide adequate support systems, especially for women

Implications for Health Service Providers (continued)

- Train peers, parents, professors, and other campus gate-keepers to identify and facilitate successful early interventions with potential suicide attempters

Violence reduction programs for Asian-American students should attempt to:

- Remove taboos around discussing violence, especially sexual assault
- Examine the impact of culture-specific sex role norms
- Break down cultural values which normalize violence
- Reframe expectations regarding female passivity and subservience
- Provide opportunities for building assertiveness, conflict resolution and anger management skills, for both men and women
- Facilitate the setting of appropriate and comfortable physical boundaries for each individual which still maintain harmony and order
- Encourage victims of violence to seek help
- Regard the Asian-American student as an empowered individual requiring assistance, rather than a powerless student who requires "saving"

Nutrition education programs for Asian-American students should attempt to:

- Encourage the intake of foods rich in calcium and iron (including dairy products and fresh vegetables)
- Stress the importance of including a variety of different foods in one's diet
- Teach students how to understand and use the food guide pyramid, as well as to properly read food labels
- Explore ways to still eat nutritiously on a low budget
- Attempt to reduce risk for hypertension by lowering sodium intake
- Reinforce such food preparation techniques as stir-frying and sparing use of meats
- Caution against including too many "American" food items (pizza, fast food, etc.) in the diet

In keeping with their immigrant heritage, Asian-Americans are resilient individuals. Resourceful and persistent, they have overcome tremendous obstacles to succeed and live in this country. These are all characteristics which can be capitalized on when empowering them to participate in their own health.

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